NOTICE - EFFECTIVE DATE OF SPEND - DOWN ELIGIBILITY

State Form 34969 (R6 / 4-00) / FI 0006A

Case name	Recipient ID (RID)	Case number	Date of notice

☐ Your Medicaid coverage is effective _____ , _____ through the end of the month. However, Medicaid will not pay $ _____ of the medical expenses you incurred on the above effective date.

If you do not agree with the effective date of your Medicaid coverage or the amount that Medicaid will not pay, you may appeal in writing to the County Office of Family and Children. You will have 30 days from the date of this notice *(see above)* to appeal.

☐ You provided $ _____ in incurred medical expenses which does not equal or exceed your Spend - down amount of $ _____ . You are therefore not eligible to receive Medicaid coverage for the month of _____ at this time.

If you do not agree with this determination you may appeal in writing to the County Office of Family and Children within 30 days of the date of this notice.

Distribution: White - To **Recipient,** Canary - To **Case record**